

Understanding the Unique Service Needs of Children Involved with Child Protective Services

“Goal 4.1: Ensure immediate delivery of ... behavioral health care to children involved with CPS.¹ Contracts with networks that provide behavioral health services must require that providers have an understanding of the unique service needs of children in foster care.”

Governor’s Action Plan for Reform of Arizona’s Child Protection System, 2004

The Importance of Situational Context

The behavioral health system should understand, as a context for its service, the situations experienced by children involved with Child Welfare. While any child might experience trauma, loss or anxiety, for example, those involved with Child Welfare are exposed to life transitions to which children with those problems who remain with their families are never exposed. In order for the behavioral health system to address the unique needs of these children, all behavioral health personnel – professionals, technicians, para-professionals and agency leadership and support staff -- must understand the unique Child Welfare context of safety, and particularly the impact of its inherent transitions, on the children, their families and other caregivers.

The following chart illustrates at a high level the various situational contexts that should be understood and appreciated:

<u>Situational Context:</u> [Look for needs in <i>non-shaded</i> areas.]	Child	Family of Origin	Temporary Caregiver	Adoptive Family/ Other Permanency
Child Remains with Own Family				
Child Placed in Foster Care				
Child Returns to Family of Origin				
Child Adopted/ Other Permanency				
Youth in Independent Living				

Working in Partnership

Efforts to meet the unique service needs of children involved with Child Welfare are best Supported when Behavioral Health, Child Welfare and other involved agencies (Juvenile Justice, DDD) and others (e.g. pediatricians, day care providers) work collaboratively towards consistent goals developed in unified service planning and funding processes.

¹ “Children involved with CPS” is operationally defined as describing children for whom DES-ACYF has an *open case* citing an *identified concern*.

Whether initiated by an [24-hour] urgent Behavioral Health response after a child's removal by CPS from their home, by placement in a higher level of care, or by a CPS referral as part of an in-home intervention plan, Behavioral Health will begin to address needs at the earliest moment. In this way BHS can help understand, shape, and align its efforts with the child's and family's Child Welfare case plan. If the child is removed from his/her family of origin, for example, with a case plan focused on reunification, then Behavioral Health interventions should support that plan. If the child must live with temporary caregivers (e.g. an uncle, a foster family), then Behavioral Health should also support those caregivers in order to achieve stability in the temporary placement, and to respond to the other identified BH needs of the child. Consistent and compatible planning through a single unified planning process including school, health care, early intervention, juvenile justice, child care or other entities can promote interagency concordance throughout the child's transitions.

Addressing the Unique Family Needs

In order to appropriately address the unique service needs of children involved with Child Welfare, interventions should extend beyond the identified needs of the child alone and should consider the needs of the family as they relate to the needs of the child. Together, Child Welfare, Behavioral Health and other involved agencies should identify resources to support the needs of both family and child.

Consider, for example, the case of infants and toddlers. The Behavioral Health system can contribute to wellness for young children by helping other involved partners to view the child holistically, and therefore to see and be able to describe the connections and implications for the children and their families. Behavioral Health expertise can help family members to appreciate the impact of their interactions on young children. They can also recognize signs, symptoms and indicators of other needs (e.g. speech delays, sensory challenges) that may impact children's social and emotional development, and should work closely with family members, pediatricians and with other early intervention partners to recognize and address such needs.

Although the involvement of CPS indicates the presence of significant safety and risk concerns and needs, Behavioral Health should comprehensively assess the strengths and resources of each child, family and their communities. These strengths and resources fortify the child's abilities at any age to cope with problems and adapt to changes (a concept called resilience).² Child Welfare, Behavioral Health and other involved agencies should coordinate their services with other public and private services and supports through individually tailored approaches that identify, apply, support and strengthen such assets, as well as address any safety and risk issues.

² Studies of resiliency in children have consistently found the most basic and important protective factor is a history of caregiver-child attachment ("*Attachment and children's mental health*," *National Child Welfare Resource Center for Family-Centered Practice*, 2003).

Families – whether the child’s family of origin, a foster family, a relative or friend providing kinship care, or an adoptive family or legal guardian -- may be supported through the individual service plan of the child with supports and/or interventions such as Respite, Family Support, Peer Support or Family Counseling. Also, services traditionally only offered by the Child Welfare system, such as Intensive Family Preservation Services, will often be necessary to stabilize the family situation and address the reasons Child Welfare is involved with the family.

Some family members, including some siblings, may also need specific individualized treatment including individual counseling or other focused interventions. In those cases, family members should obtain needed interventions as well. When a child is receiving behavioral health services, and family members are also receiving services through the Behavioral Health system, it will be important to coordinate their service plans through a unified service planning process that determines compatible and mutually-reinforcing plans that make sense to the family, and are therefore more likely to be effectively implemented.

Child Remains with Own Family

Children involved with Child Welfare often live in family homes in which CPS is actively monitoring identified concerns relating to safety, security or basic needs. Likely emotional responses of the child might include: disturbed parent-child and child-sibling relationships, disrupted capacity for trust and attachments, anxiety, developmental delays, compromised learning, dysfunctional coping skills, behavioral disorders, post traumatic stress disorder and/or mood disturbances.

As CPS works with the extended family, community and service providers to bolster and maintain a functioning family and a secure and nurturing environment, the child who remains in the family home may require individually tailored behavioral health services to meet specific needs for assistance with emotional disturbances.

The child needs assurance of a positive and safe future – that he/she can rely on the adults in the household to place his/her needs first, and perhaps even to develop or strengthen supportive relationships with other adults as well. To meet these unique needs, services with most families will need to be intense, comprehensive and delivered quickly in order to maximize engagement with family and strengthen their support system with added resources.

Parents in this situation should be helped to learn/know how to manage their child’s unique needs, and to anticipate and respond to those needs as they change in the future. Services and supports provided to such families should be designed to impart skills and confidence to the parents, while protecting the children (i.e. to limit and reduce risk of harm to them) to prevent a need for their removal to foster care.

Any and all covered services that promote permanency and a child's ability to live and thrive safely in their own homes, should be provided.

Child Is Removed to Protective Foster Care

CPS may remove children from their family homes to protective placements (shelters, receiving foster homes, relative ["kinship"] placements, regular family foster homes, or group homes). A child who may have been seriously neglected within the family home, or abused (physically, sexually, emotionally), is thus affected not only by the neglect or abuse that precipitated removal to protective foster care; but may further now experience disorientation and uncertainly related to this drastic change in circumstances.

Children in foster care experience a combination of risk factors, starting with the trauma of separation from their parents. Many children also experience separation from brothers and sisters, loss of pets, moves from familiar neighborhoods, changes of school, loss of friends, loss of comfort objects, and the challenges of unfamiliar caretakers, routines, and expectations. They will often lack well-developed coping skills based on survival needs to support them through such tumult, so their experiences make them vulnerable to psychological problems.

Likely emotional responses by children to this situation might include: disorientation and anxiety-related behaviors (e.g. impulsivity, sleep problems, somatization); effects of trauma³ (e.g. blunted affect, extreme detachment, dissociation); mistrust (suspicious, hyper-vigilant) or even a disrupted capacity for trust and attachments (insecure, avoidant, overanxious, disorganized); anger (aggression, lying, stealing); sexualized behaviors; victim identification (including intense alignment with the abusive parent); regression; problematic responses to deprivation (e.g. insatiable appetite, hoarding, territoriality); shame, self-blame and even self-injurious behaviors. Many turn to substance abuse,⁴ or simply attempt to run away⁵ in futile efforts to escape such feelings.

The child removed to protective foster care may require individually tailored behavioral health services, perhaps including services requiring specialized clinical expertise, to meet specific needs for assistance with emotional disturbances. The child needs assurance that his/her past, present and future attachments need not be disrupted.

³ Saltzman, W.R., Pynoos, R.S., Layne, C.M. et al. (2001), *Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol*. *Group Dynamics: Theory, Research and Practice*, 5(4):291-303: When failing adolescent students with severe PTSD symptoms were recognized and treated for trauma, their symptoms were markedly reduced, they required no further discipline, and their grade point averages went up significantly.

⁴ Clark, H.W., McClanahan, T.M. & Sees, L.K. (Spring 1997), *Cultural aspects of adolescent addiction and treatment*. *Valparaiso University Law Review*, Vol.31(2). Adolescents with alcohol dependence are six to 12 times more likely to have a childhood history of physical abuse, and 18 to 21 times more likely to have a history of sexual abuse than those without substance abuse problems.

⁵ Deborah Bass, "Study of Runaway Youths Finds One-Third Were In Foster Care," *St. Louis Post-Dispatch*, (January 19, 1992). [results of a survey of 170 runaway shelters.]

The child needs supportive relationships. The child also needs to be able to trust that “all of the adults in my life are on the same page” [Child and Family Teams are one way to support this⁶], and that “I can rely on them to be in my life over time.”

“Most professionals in child welfare recognize that foster parents are in a central position to know about and care for the foster child’s emotional well-being. The mental health of children in foster care is closely linked to the relationships in foster care, the birth family, and with all providers that are supporting the placement. When a foster child has challenging psychological problems, like major depression, bipolar disorder, or serious anxiety reactions, the role of foster families as emotional stabilizers and mediators is critical.”⁷

Foster parents and other protective caregivers, in particular, will need guidance and support to raise children facing such daunting challenges. They will need to understand, for example, the strong sensory base to an infant’s experience of interactions with people and with the world; and how to see possible indicators of the young child’s adjustment through behavior, as they may see the infant’s through eating, sleeping and other bodily functions. They will need to understand that, as children make gains with receptive and expressive language and with cognitive development, then they will have increasing capacity to identify and describe how they are reacting to or coping with new situations, how it feels and perhaps even what might help them to feel better. Foster parents will also need to be considered as significant, knowledgeable members of the service team, receiving well-integrated coordination by, and clear communication from, all involved systems.

The child’s own parents, meanwhile, may need to be convinced that “my child needs me sooner rather than later,” and need to learn how to analyze and solve problems with other people, especially in relationship to the protective needs of the family.

The Behavioral Health system can help not only families, foster care and kinship caregivers, but perhaps also Child Welfare workers, court-appointed special advocates (CASAs), judges and attorneys to understand the importance of their respective relationships with the child, his/her social development and therefore overall healthy development.

Some children appear to make good adjustments to foster care. Traditional referral of foster children by Child Welfare for behavioral health screening/assessment and treatment was largely predicated on recognition of evident symptoms (usually externalized behaviors). Children not demonstrating obvious symptoms, on the other hand, were not referred at all. Frequently, it turned out, those same children were found

⁶Indeed, the very composition of the Child and Family Teams must “include, at a minimum, the child and his/her family, any foster parents [emphasis added], a behavioral health representative, and any individuals important in the child’s life and who are identified and invited to participate by the child and family.” ADHS Practice Improvement Protocol #9: The Child and Family Team (August 2003).

⁷ Roger Friedman PhD LCSW, “A cautionary tale and five hard lessons: Foster families as partners in child mental health,” in Best Practice: Next Practice (Summer 2003).

over time to have been suffering *internal* psychological pain due to internal conflict associated with the circumstances surrounding the Child Welfare involvement and were more in need of services than those children who acted out. These children revealed their actual needs when the reasons for internalizing their behaviors were no longer present, either due to maturity, time or a change in circumstances, often only weeks, months or even years after entering foster care, when they began to act out their anger towards others, run away, to abuse alcohol or other drugs, or to cut on themselves.

Thus, foster children who do not initially demonstrate overt mental health symptoms will benefit from close observation and documentation by trained eyes (“surveillance,” in public health parlance). And those who may be fortunate to weather their initiation into foster care without apparent ill effects will certainly benefit from activities and strategies that help to fortify their resilience,⁸ and to anticipate and prepare them for subsequent life transitions inherent in Child Welfare and passage into adulthood.

Many children experience multiple placements while in protective custody of Child Welfare. Behavioral Health, Child Welfare and other involved agencies, as well as families and communities, need to work together to stabilize and strengthen protective placements to prevent the child’s “disruption.” Each such transition – whether planned or unplanned – might be experienced by the child as a whole new round of devastating losses (or at least of significant new challenges). Disruption drastically impacts the world of even the very youngest children, by threatening the building of relationships, their developmental processes, their emerging senses of “self” and understanding of people and the world. Organizing models that keep people who are significant to the child involved in the planning for placement transitions should be implemented, so that as much as possible children are returned to the same caregivers, thus supporting increased stability and permanency.

Child Returns to His/Her Family of Origin

Children who have been living apart from their families of origin have had time to adapt to new expectations, interactions, roles and processes. Coping skills and behavioral response patterns have likely adjusted to the dynamics of the protective foster caregivers, which may be distinct from those of their families of origin. Families of origin have likely adjusted to new status quos that have not included the child.

Regardless of the planning and work that has been done in advance of the child’s returns, reunification is stressful and difficult. As yet unresolved issues relating to neglect, abuse, abandonment, fear and mistrust may resurface as the child returns home. Memories and symptoms of post-traumatic stress disorder may be triggered by re-exposure to the home environment. Familiar but unsuccessful family patterns may return and replace recently learned adaptive dynamics.

⁸ See, for example, 40 Developmental Assets, Search Institute (2004), at <http://www.search-institute.org/assets/>

Children will require tailored and individualized behavioral health services to meet the specific needs that stem from reunification. They will need to feel embraced and re-accepted by their reunified families, to feel wanted permanently, to feel the assurance that their families will put the children's needs first, and to feel confident that the stay with their families will last. When safety issues do emerge, children and parents need to feel that they will be supported in having frank and open discussions about these issues with service providers and Child Welfare professionals who understand these issues, are unified in their approach to the family, work well together and will assist them in coordinated planning to adequately address these issues when they arise.

*"The problems of these children are not likely to disappear once they are adopted or reunified with their families. Therefore children and parents need post-adoptive or post-reunification services to help them deal with lifelong effects of abuse, neglect and separation."*⁹

Parents are likely to need confidence that they have developed the strength and skills necessary to successfully provide for their children, to meet their needs, and to keep them safe.

Temporary caregivers, such as relatives or foster parents, will need to be prepared to cope with the losses of the child and, as much as possible, stay connected to the child and the family of origin both during and after the transition back to the family.

All involved parties will need to understand what has been learned about optimal transition processes, given the child's age (e.g. the younger the child, the shorter the transition), and to know how to support that from their respective positions.

Adoption/Other Permanency (e.g. Guardianship)

Children who leave foster care for other permanent situations (adoption, guardianship) may experience significant feelings of loss, at the same time their permanency is viewed as a success by CPS, the Court, their new families and even themselves. Indeed, adopted children may experience feelings of isolation and being different. They may feel irreversibly abandoned by their families of origin, engendering anger, feelings of guilt and even self-blame, while at the same time experiencing feelings of gratitude, inclusion and acceptance. In many cases, the adopted child may experience the loss not only of both natural parents, but also of extended family, of cultural and genealogical heritage, of a sense of connectedness, of former social status -- of Self. Unlike in cases of divorce or death, these losses are rarely recognized in the context of adoption, and few supportive rituals are available to children experiencing them.

Children entering new ties through adoption or guardianship will strive to gain a sense of identity and belonging – a feeling of “fitting in” – in their new home and community. Given their prior losses, they are likely to need much reassurance that “I am wanted, no

⁹ National Child Welfare Resource Center for Family-Centered Practice, 2003.

matter what I do or how I act.” Many will choose to test limits repeatedly to try the strength of their new ties as they adjust to the need for having an identity and sense of belonging in their home and community. Children in adoptive or guardianship situations will need to know that their past will be considered by others and included in their futures.

These emotional responses may occur on top of his/her already-accumulated needs related to initial (and sometimes chronic) abuse and neglect, the trauma of separation at the point of removal from all that has been familiar, the adaptation challenge posed to the child by his/her strange new world of foster care, and the additional transitions the child may have endured within foster care.

The child’s new family will need adequate preparation and planning for successfully absorbing a new family member prone to emotional issues. Services will need to be readily available, consistent and prepared to meet the unique needs of children and adoptive families. Parents need to feel fully recognized as the child’s parent, and at the same time that they will know what to do when faced with the child’s adjustment issues over time.

A recent survey of 375 Maine families who had adopted children from foster care an average of six years earlier¹⁰ reported these problems persisting in at least half of those children:

“Sudden changes in mood or feelings (82%); argues too much (75%); difficulty concentrating (75%); impulsive, acts without thinking (75%); disobedient at home (74%), stubborn, sullen (71%); cheats or tells lies (70%); high-strung, tense or nervous (61%); has trouble getting along with other children (60%); very strong temper, loses it easily (60%); restless, overly active (59%); does not seem to feel sorry after misbehaving (57%); fearful or anxious (55%); disobedient at school (53%); not liked by other children (52%); has obsessions (52%); and easily confused (51%).”

These problems were identified within stable adoptive families of relatively long standing. Yet after an average of six years since finalization of the adoptions, 38% of parents rated the child’s *current* adjustment as “somewhat difficult,” as 12% as “very difficult.”

If there are still safe people from their family of origin or past support system who are important to a child, then those people should be involved in the child’s life as much as possible. This may require assistance over time by the behavioral health provider to assist the involved children and families to ensure that there are successful connections to the child’s past, including involving these people in the planning and treatment process.

¹⁰ John Levesque and Michael Lahti, *Maine Adoption Guides Project, “Maine Post-Adoption Legalization Survey: Child and Family Needs and Services,” DHHS IV-E Demonstration Project, January 2002.*

Independent Living

Synthesis of interviews of 40 young people who have been in the foster care system¹¹ found “the recurring theme of the kids’ stories: the stigma young people in foster care carry, and their overwhelming desire to be free of it – to be seen in the world as themselves, actors in their own lives, not merely objects of pity, disdain, fear, or even care.”

For those children who reach the age of majority while in State custody, their unique service need is multi-dimensional. Some may continue to have behavioral health needs that will be addressed through services associated with their eligibility for general mental health, substance abuse and/or serious mental illness. Some young people may also continue their involvement with Child Welfare on a voluntary basis.

Most of these youth will still have close connections with others from their past, such as siblings, family, friends, educators, church communities and others. Young people need to know that the system who is acting as their primary caregiver and support will respond quickly to meet their needs, involve current support systems, plan for their needs adequately, stay involved in their lives and assist them to transition to adulthood in a way that teaches them the skills they need to thrive and support their continuing needs, including continued adult mental health issues that are present or emerge over time.

For many, housing and employment are critical needs at this point. Up to one-third of children placed in foster care eventually end up homeless.”¹² Addressing such variables requires specific focus, coordination and case planning from both Child Welfare and from Behavioral Health, as well as other involved agencies such as the Juvenile Justice system.

¹¹ Nell Bernstein, editor, “A Rage to Do Better: Listening to Young People from the Foster Care System,” (San Francisco: Pacific News Service)

¹² Testimony of Dennis Lepak, Contra Costa Co. (CA) Probation Department, in Foster Care, Child Welfare, and Adoption Reforms, Joint Hearings before the Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means and the Select Committee on Children, Youth and Families, U.S. House of Representatives, April 13 and 28, May 12, 1988.